BRADFORD FAMILY MEDICINE, INC.
REVIEW OF SYSTEMS

Patient Name:_____ **Date of Birth:**_____**Today's Date:**_____
(Last) (First) (MI)

Please mark any of the following symptoms that you have experienced in the last three months and provide details in the space below if applicable

General:

Weight loss Weight Gain Fever Chills Night Sweats Fatigue Weakness Dizziness
Other_____

Skin/Hair/Nails:

Rash Itching Sores Lumps Changing Moles Dryness Hair Changes
Nail Changes Other_____

_____

Head/Eyes/Ears/Nose/Throat:

Headaches Blurry/Double Vision Light Sensitivity Itchy Eyes Watery Eyes
Hearing Loss Ringing in Ears Room Spinning/Dizziness Earaches Ear Drainage
Congestion Runny Nose Sneezing Nose Bleeds Environmental Allergies
Post-Nasal Drip Sore Throat Hoarseness Difficulty Swallowing Bleeding Gums
Dental Pain Other_____

_____

Respiratory:

Cough Wheezing Shortness of Breath Coughing/Spitting up Blood Other_____

_____

Cardiac:

Chest Pain Palpitations Shortness of Breath Shortness of Breath with Exertion
Shortness of Breath Lying Flat Waking up Suddenly Short of Breath Leg Swelling Other

_____

Gastrointestinal:

Appetite Changes Heartburn/Indigestion Nausea Vomiting Diarrhea Constipation
Blood in Stool Black/Tarry Stool Stomach Pain Yellowing of Skin Other_____

_____

Patient Name:_____ **Date of Birth:**_____**Today's Date:**_____
(Last) (First) (MI)

Genitourinary:

Pain with Urination Frequent Urination Urgency Difficulty Voiding Blood in Urine
Nighttime Urination Loss of Urine Unintentionally Frequent Infections Hernia
Testicular Pain/Lumps (males) Vaginal Discharge (females) Vaginal Dryness/Irritation (females)
Irregular Periods/Abnormal Bleeding (females) Hot flashes Other_____

_____

Vascular/Musculoskeletal:

Leg Cramps with Walking Varicose Veins Blood Clots Gout Muscle Weakness
Joint Pain Joint Stiffness Joint Swelling/Redness Other_____

_____

Neurological:

Numbness Tingling Paralysis Weakness Shaking/Tremors Fainting Blackouts
Seizures/Convulsions Slurred Speech Other_____

_____

Hematological:

Anemia Easy Bruising Easy Bleeding Blood Transfusions Swollen Glands Other

_____

Endocrine:

Intolerance to Heat Intolerance to Cold Excessive Sweating Frequent/Large Amounts of Urine
Excessive Thirst Other_____

Psychiatric:

Anxiety/Nervousness Depression/Sadness Increased Stress Hallucinations Hearing Voices
Thoughts of Suicide Mood Swings Other_____

_____